OCCUPATIONAL THERAPY
CASE HISTORY / INTAKE FORM

Chatty Child™
Speech & Occupational Therapy, PLLC

CHILDS INFORMATION

Child's Full Name

Child's Nickname(s)

Child's Preferred Pronouns

Child's Date of Birth

Chronological Age

Adjusted age (if applicable)

Street Address

City, State Zip

Home Tel

CAREGIVERS INFORMATION

Primary Caregiver:
Name

Preferred Pronouns

Occupation

Cell

Work Tel

Email

Primary Caregiver 2:
Name

Preferred Pronouns

Occupation

Cell

Work Tel

Alt Caregiver's Name

Email

Alt Caregiver's Cell

REFERRAL

325 Broadway - Suite 403, New York, New York 10007
tel/fax 347.491.4451 email chattychildny@gmail.com
www.chattychild.com

For Office Use Only:
☐PRIVATE ☐ DOE ☐ EI
☐SP ☐ OT ☐ BOTH
☐ Added to Database
☐ Scanned & Filed

Referred By

Reason for Referral

CURRENT STATUS / CONCERNS

Does your child have a medical diagnosis? If yes, please list.

What are your present concerns? Please list.

Have your concerns changed? Please explain.

Has the problem gotten better, worse or stayed the same in the last year?

What are your primary concerns with your child's fine motor/ gross motor development? Sensory needs?

SOCIAL HISTORY

With whom is the child living?

Please list names and ages of child's siblings (if applicable)

Who are the primary caregivers?

BIRTH EXPERIENCE

How was the birthing parent's pregnancy experience?

Any illness during pregnancy? Please list.

Any medications taken during pregnancy? Please list and explain.

What medical tests were taken during pregnancy? Please list and explain.

Any medications taken during pregnancy? Please list and explain.

Any alcohol or drugs used during pregnancy?

Length of pregnancy in weeks?

Duration of labor?

Type of delivery?

List any problems during labor and/or delivery:

Apgar Scores

Was respiratory supports needed?

MEDICAL HISTORY

List any medications your child is currently taking:

List any medications your child has taken in the past:

Any surgeries or medical interventions? If yes, please explain.

Has your child experienced any of the following, if so please describe:

Ear Infection

Allergies

Asthma

High Fevers

Seizures

Frequent Upper Respiratory Infections

Pneumonia

Other illnesses (list)

Genetic Testing

Neurological Testing

Medical Diagnosis

Does your child experience regular bowel movements?

Is your child toilet trained?

MOTOR MILESTONES

When did your child first:

Roll Over (did your child roll both ways)

Sit up

Crawl

Walk

Run

Jump

What is child's hand preference?

Describe any fine motor concerns.

Describe any gross motor or physical concerns.

Describe any Sensory concerns.

Does your child like/ dislike messy play?

Does your child avoid certain thing/ equipment on the playground?

Does your child demonstrate any hyper or lethargic behaviors?

SPEECH & LANGUAGE

How does your child communicate their needs?

Does your child answer questions easily or with difficulty?

Does your child follow directives easily or with difficulty?

Does your child communicate with gestures, words, or sentences?

Describe any speech concerns you may have?

SLEEP PATTERNS

What is child's usual bedtime and rise time?

Does your child still nap? For how long?

Any sleep problems? Describe your child's sleep patterns.

Is your child irritable? If so, at what times?

CHILD'S PERSONALITY

Describe child's likes:

Describe child's dislikes:

What toys does your child enjoy?

What fears does your child have?

What does your child find frustrating?

How is your child disciplined?

What kinds of things can the child do for themselves?

Dressing	Eating
Bathing	Fasteners (buttons, zippers, etc.)
Toileting	Other